February 2008 Medicaid Bulletin

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Attention: All Providers

Importance of One to One Enumeration

N.C. Medicaid strongly recommends that providers obtain an NPI for each active Medicaid Provider Number. Providers should mirror their Medicaid enrollment when enumerating. The only exception is for sole proprietors, who are able to obtain only one individual (Type I) NPI.

When NPI is implemented, claims will continue to process through the current MMIS system. Therefore, N.C. Medicaid has designed a mapping solution to crosswalk the NPI to the current Medicaid Provider Number. Ideally, each NPI will crosswalk to only one Medicaid Provider Number, otherwise known as a "one–to-one" match. If the NPI crosswalks to multiple Medicaid Provider Numbers, the NPI will have a "one-to-many" match. If a one-to-many match occurs, the mapping solution will determine the appropriate Medicaid Provider Number by taking the claim through a series of steps. Information such as ZIP+4 and taxonomy will play important roles in determining the appropriate Medicaid Provider Number. If the mapping solution cannot narrow down to one Medicaid Provider Number, payment could be delayed due to the additional research needed to process the claim.

To request additional NPIs, providers should complete an application by visiting the NPPES Web site: https://nppes.cms.hhs.gov. (Click on the link in the paragraph beginning, "If you are a Health Care Provider, …")

NPI – Get it! Share It! Use It! Getting one is free – Not having one can be costly!

EDS, 1-800-688-6696 or 919-851-8888

Attention: Pharmacists

NPI Update for Pharmacy Providers

Effective March 1, 2008, pharmacy providers are encouraged to begin submitting their NPI number to N.C. Medicaid. Currently, the system accepts either an NPI or a Medicaid Provider number. A valid qualifier of 01 for NPI or 05 for Medicaid is required in the Service Provider ID Qualifier field (202-B2). If an invalid qualifier is submitted after March 1, 2008, the claim will be denied.

The N.C. Medicaid HIPAA Companion Guide Specifications for NCPDP 5.1 will be updated with the following information:

Field #	Field Name	Format	Field/Type	Field Length	NC Medicaid Specifications
202-B2	Service Provider ID Qualifer	NCPDP V5.1	A/N	2	01 = NPI 05 = Medicaid
466-EZ	Prescriber ID Qualifier	NCPDP V5.1	A/N	2	01 = National Provider Identifier (NPI) 12 = Drug Enforcement Administration (DEA)

Prescriber ID
Until further notice, please continue submitting the DEA number as the prescriber ID.

Reversals
All reversals submitted with the NPI as the billing provider number require the recipient's Medicaid identification number in addition to the billing provider number, date of service and prescription number.

NPI – Get it! Share It! Use It! Getting one is free – Not having one can be costly!

EDS, 919-851-8888 or 1-800-688-6696

Attention: All Providers

Taxonomy Billing Tips

Taxonomy codes identify the provider type and area of specialization for health care providers. They are 10-character alphanumeric codes that allow providers to identify their specialties. Refer to the DMA NPI website for a list of DMA recommended taxonomy codes: http://www.ncdhhs.gov/dma/NPI.htm. This is not an all inclusive list of codes. A full list of taxonomy codes is located on the Washington Publishing Company Web site: http://www.wpc-edi.com/codes/taxonomy. Refer to this site, if you do not see your service listed on the DMA recommended taxonomy code list.

With the exception of pharmacy providers, all providers are required to submit taxonomy codes on all claims. There are a few rules to follow when submitting taxonomy codes.

For institutional (UB) providers: Submit the taxonomy for the billing provider number only. Attending taxonomy is not required on a UB claim.

For professional (CMS-1500) providers: According to the 837 guidelines, only one taxonomy per claim is allowed. If an attending provider number is present on the claim, enter the attending provider's taxonomy and leave the billing taxonomy field blank. If no attending provider number is present, submit the taxonomy for the billing provider number. Providers will receive an error message if both an attending and a billing taxonomy are present on the same claim.

NPI – Get it! Share It! Use It! Getting one is free – Not having one can be costly!

EDS, 1-800-688-6696 or 919-851-8888

Attention: All Providers (Except Pharmacy)

Update on the NPI, Medicaid Provider Number and Taxonomy Denial Edit

In the January 2008 provider bulletin, DMA published that claims would deny effective March 1, 2008, if the NPI, Medicaid provider number and/or taxonomy was missing. Based on analysis of recent claims, DMA has decided not to implement the denial edit effective March 1.

DMA still requires that, with the exception of pharmacy, all submitted claims contain the Medicaid Provider Number, NPI, and Taxonomy. This data is needed to ensure that providers' claims are mapping and paying to the correct Medicaid Provider Number prior to the May 23, 2008, NPI implementation.

NPI – Get it! Share It! Use It! Getting one is free – Not having one can be costly!

EDS, 1-800-688-6696 or 919-851-8888

Attention: All Providers

Basic Medicaid Seminars

Basic Medicaid seminars will be held in several locations in April 2008. Seminars are intended to educate providers on the basics of Medicaid billing.

The seminar sites and dates will be announced in the March 2008 general bulletin, which will be posted to http://www.ncdhhs.gov/dma/bulletin.htm. Pre-registration will be required. Due to limited seating, registration is limited to two staff members per office. Unregistered providers are welcome to attend if space is available.

EDS, 1-800-688-6696 or 919-851-8888

Attention: All Providers

Clinical Coverage Policies

The following new or amended clinical coverage policies are now available on the Division of Medical Assistance's Web site at http://www.ncdhhs.gov/dma/mp/mpindex.htm:\

- 3A, Home Health Services
- 5A, Durable Medical Equipment (posted 1/9/2008)
- 5B, Orthotics and Prosthetics
- 8A, Enhanced Mental Health and Substance Abuse Services
- 9, Outpatient Pharmacy Program (posted 1/17/2008)

These policies supersede previously published policies and procedures. Providers may contact EDS at 1-800-688-6696 or 919-851-8888 with billing questions.

Clinical Policy and Programs
DMA, 919-855-4260

Attention: All Providers

HCPCS Procedure Code Changes for Diagnostic Radiopharmaceutical, Diagnostic, and Low Osmolar Contrast Agents

End-Dated Codes with No Replacement Code

Effective with date of service Dec. 31, 2007, the following HCPCS procedure codes were end-dated. Claims submitted for dates of service on or after Jan. 1, 2008, using the end-dated codes will be denied. These radiopharmaceuticals are no longer commercially available.

End-Dated HCPCS Code	Description	Unit
A9546	Cobalt Co- 57/58 cyanocolalamin, diagnostic	Up to 1 µCi
A9568	Technetium Tc-99m arcitumomab, diagnostic	Per study dose, up to 45 mCi

New Codes without Replacement Codes

The following HCPCS procedure codes for diagnostic radiopharmaceutical, diagnostic, and low-osmolar diagnostic agents are covered effective with date of service Jan. 1, 2008.

HCPCS Procedure Code	Description	Unit
A9501	Technetium TC-99m teboroxime, diagnostic	Per study dose
A9509	Iodine I-123 sodium iodine, diagnostic	Per mCi
A9535	Methylene Blue	Per ml
A9569	Technetium TC-99m exametazime labeled autologous white blood cells, diagnostic	Per study dose
A9570	Indium In-111 labeled autologous white blood cells, diagnostic	Per study dose
A9571	Indium In-111 labeled autologous platelets, diagnostic	Per study dose
A9576	Gadoteridol (prohance multipack)	Per ml
A9577	Gadobenate dimeglumine (multihance)	Per ml
A9578	Gadobenate dimaglumine (multihance multipack)	Per ml
A9504	Technetium Tc-99m apcitide, diagnostic	Per study dose, up to 20 mCi
A9507	Indium In-111 capromab pendetide, diagnostic	Per study dose, up to 10 mCi
A9508	Iodine I-131 iobenguane sulfate, diagnostic	Per 0.5 mCi
A9524	Iodine I-131 iodinated serum albumin, diagnostic	Per 5 µCi
A9526	Nitrogen N-13 ammonia, diagnostic	Per study dose, up to 40 mCi

HCPCS Procedure Code	Description	Unit
A9529	Iodine I-131sodium iodide solution, diagnostic	Per mCi
A9532	Iodine I-125 serum albumin, diagnostic	Per 5 µCi
A9558	Xenon Xe-133 gas, diagnostic	Per 10 mCi
A9559	Cobalt Co-57 cyanocobalamin, oral, diagnostic	Per study dose, up to 1 µCi
A9567	Technetium Tc-99m pentetate, diagnostic, aerosol	Per study dose, up to 75 mCi

New Codes with Replacement Codes

Some new codes have replaced old codes that were end-dated with date of service Dec. 31, 2007. Claims submitted for dates of service on or after Jan. 1, 2008, using the end-dated codes will be denied.

Old			New		
HCPCS Procedure Code	**Description**	**Unit**	**HCPCS Procedure Code**	**Description**	**Unit**
Q9945 through Q9950	Low Osmolar Contrast Material	Up to 400 mg/ml iodine concentration	**Q9965**	Low Osmolar Contrast Material 100–199 mg/ml iodine concentration	Per ml
			Q9966	Low Osmolar Contrast Material 200–299 mg/ml iodine concentration	Per ml
			Q9967	Low Osmolar Contrast Material 300–399 mg/ml iodine concentration	Per ml
Q9952	Gadolinium-based magnetic resonance contrast agent	Per ml	**A9579**	Gadolinium-based magnetic resonance contrast agent, not otherwise specified	Per ml
A9565	Indium In-111 pentetreotide, diagnostic	Per mCi	**A9572**	Indium In-111 pentetreotide, diagnostic	Per study dose, up to 6 mCi

Providers are reminded to bill their usual and customary charges.

Refer to the fee schedule for the Physician's Drug Program on DMA's Web site at http://www.ncdhhs.gov/dma/fee/fee.htm for the latest available fees.

EDS, 1-800-688-6696 or 919-851-8888

Attention: All Providers

CPT Code 77003

CPT code 77003 *(fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures, including neurolytic agent destruction)* was a new code effective January 1, 2007. Audits were established to prevent CPT 77003 billed without modifier 26 from being billed with CPT codes 62310, 62311, 62318 and 62319. Claims payment system changes have been made to correct the problem. Effective with date of service January 1, 2007, providers may bill CPT code 77003 for the global service, for the professional component (modifier 26) or for the technical component (modifier TC) when billing CPT 77003 with 62310, 62311, 62318 and 62319. Providers who received claim denials related to EOB 4237 or 4238 for CPT code 77003 may resubmit new claims (not adjustments) for processing.

EDS, 1-800-688-6696 or 919-851-8888

Attention: All Providers

CPT Code 77002 Denials

CPT code 77002 (*fluoroscopic guidance for needle placement*) was a new code effective January 1, 2007. Claims have incorrectly denied when 77002 was billed with CPT code 20610 (*arthrocentesis, aspiration and/or injection; major joint or bursa*). Claims payment system changes have been made to correct the problem.

Providers, who received claim denials or claims were recouped for CPT codes 77002 and 20610, may resubmit new claims (not adjustments) for processing if claims were denied or recouped with the following EOB:

- **EOB 1651** – "Component procedure not allowed same day as comprehensive procedure."
- **EOB 1655** – "Comprehensive procedure paid. Component procedures will be recouped."

EDS, 1-800-688-6696 or 919-851-8888

Attention: All Providers

Instructions on Inquiry Requests

Providers are able to contact EDS and the Division of Medical Assistance (DMA) for claim inquiries by telephone and/or by mail. Resources are available on the DMA Web site to instruct providers on how to properly submit a claim inquiry and whom to contact for help with your particular question.

The ***Basic Medicaid Billing Guide*** (http://www.ncdhhs.gov/dma/medbillcaguide.htm) contains all forms, addresses, and telephone numbers that are available to providers. Each appendix in this document contains important information for inquiry requests.

Appendix A: Automated Voice Response System (AVRS)—This section lists various options for providers that are useful for basic inquiries, such as claim status, checkwrite information, drug coverage, pricing information, prior approval, recipient eligibility, primary care provider (PCP) information, and consent form status.

Appendix B: Contacting EDS—Telephone Instructions—All options available within the EDS 1-800-688-6696 telephone line are listed here.

Appendix C: Contacting Medicaid—All mailing addresses and telephone numbers to contact EDS and DMA departments are available in this appendix. There are also Web site references for additional information on specific topics.

Appendix D: EDS Provider Services Representatives—EDS Provider Services has provider-specific travel representatives available to visit offices, facilities, billing sites, etc., for billing inquiry questions. Appendix D lists the names of the EDS travel representative by county (shown in territory groups). To request a travel representative visit, call EDS Provider Services at 1-800-688-6696, option 3.

Appendix E: Requesting Forms—All N.C. Medicaid forms are either available on the DMA Web site at http://www.ncdhhs.gov/dma/forms.html or can be ordered through the contact information listed here.

Appendix F: List of Abbreviations—Alphabetic abbreviations in the *Basic Medicaid Billing Guide* are defined here, and forms are indexed by number.

Appendix G: Provider Forms—All general provider forms are pictured in this appendix.

Appendix H: New Claim Form Instructions—Sample claim forms are shown in Appendix H along with a link to the June 2007 special bulletin, *New Claim Form Instructions*.

The ***Basic Medicaid Billing Guide*** is updated twice a year. Please be sure to consult the most current edition for each claim inquiry.

EDS, 1-800-688-6696 or 919-851-8888

Attention: All Providers

Update: Meningococcal Conjugate Vaccine (Menactra, MCV4, CPT 90734) Expansion in the UCVDP/VFC Program

Effective immediately, the Universal Childhood Vaccine Distribution Program/Vaccines for Children Program (UCVDP/VFC) has expanded its coverage criteria for meningococcal conjugate vaccine (MCV4, Menactra). Based upon recommendations from the Advisory Committee on Immunization Practices (ACIP), UCVDP/VFC will provide vaccine for children 2 through 10 years of age who are at increased risk for invasive meningococcal disease.

According to recent ACIP recommendations, MCV4 is preferable to meningococcal polysaccharide vaccine, MSPV4 (Menomune), for children 2 through 10 years of age who are at increased risk for meningococcal disease. These children include

1. those who have traveled to, or are residents of, countries in which meningococcal disease is hyperendemic or epidemic;
2. those who have terminal complement component deficiencies, and
3. those who have anatomic or functional asplenia.

Additionally, MCV4 is preferred to MPSV4 for use among children 2 through 10 years of age for control of meningococcal disease outbreaks. For the complete revised recommendations for children 2 though 10 years of age, go to http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5648a4.htm?s_cid=mm5648a4_e.

For persons 11 through 18 years of age for whom routine vaccination is recommended, the recommendations were previously published and remain unchanged. To view the ACIP recommendations for children 11 through 18 years of age, go to http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5631a3.htm?s_cid=mm5631a3_e.

Effective with date of service Feb. 1, 2008, the N.C. Medicaid program will now reimburse for the administration of MCV4 for VFC children from 2 through 18 years of age. Medicaid also reimburses for MCV4 for recipients 19 through 55 years of age according to the recommendations of ACIP.

Note the following EPSDT Related Information:
1. The decision to approve or deny a request for the above vaccine that exceeds the guidelines specified in the above article will be based on the recipient's MEDICAL NEED to correct or ameliorate a defect, physical [or] mental illness, or condition [health problem]. "Ameliorate" means to improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

2. The specific coverage criteria (e.g., particular diagnoses, signs, or symptoms) specified in the above article do NOT have to be met for recipients under 21 years if medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problems].

3. Any limitations on scope, amount, or frequency of the service or age of the recipient referred to in the above article do NOT apply to recipients under 21 years of age if **MEDICALLY NECESSARY** to correct or ameliorate a defect, physical or mental illness, or condition [health problem]. Under EPSDT, vaccines (like any other Medicaid service) may be prescribed as often as needed for any Medicaid recipient under age 21 if it is medically necessary to correct or ameliorate the recipient's health problem.

4. Other restrictions specified in the publications above may be waived under EPSDT as long as exceeding those restrictions is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem].

5. All other EPSDT criteria specified in the EPSDT policy instructions must be met to approve the request.

6. For further information about EPSDT, including how to submit the form for approval of the service, see the August 2007 EPSDT Policy Instructions Update at the website specified below. http://www.dhhs.state.nc.us/dma/EPSDT/EPSDTPolicyInstructionsUpdate081707.

EDS, 1-800-688-6696 or 919 688-6696

Attention: Home Health Agencies and Home Infusion Therapy Providers

Provision of Drug Infusion Therapy by the Home Infusion Therapy Provider Concurrently with Home Health Services.

Home health services provided to a Medicaid recipient while receiving home infusion therapy drug therapy provided through a Home Infusion Therapy (HIT) provider are covered by the Medicaid program. The medical need for the home health service must be unrelated to the provision of the drug therapy to be considered a separate billable service.

Medicaid will reimburse the home health agency for the individual visits and services billed as ordered by the physician and listed on the plan of care. The HIT provider will be reimbursed for the drug infusion therapy as a per diem inclusive of supplies, training, delivery, pharmacist and nursing services. However, when the recipient is dually eligible under Medicare and Medicaid and the home health services are being billed to Medicare, the HIT provider cannot bill Medicaid for reimbursement for the provision of a home drug infusion therapy. Medicare reimbursement for home health services is under a prospective service fee that is all inclusive. Billing the HIT drug therapy per diem would be considered a duplication of services and therefore not reimbursable by Medicaid. The home health agency should include all medical care needs of the recipient within the episode of care in accordance with Medicare reimbursement guidelines.

EDS, 1-800-688-6696 or 919-851-8888

Attention: Home Health Agencies, Community Alternatives Program Case Managers and Private Duty Nursing Providers

2008 HCPCS Code Changes to the Home Health Fee Schedule

The following code changes were made to the Home Health fee schedule to comply with the Centers for Medicare and Medicaid Services (CMS) 2008 HCPCS coding update.

Effective with date of service December 31, 2007, the following codes were deleted.

CODE	DESCRIPTION
B4086	Gastrostomy/Jejunostomy tube, standard, any material, any type, each
B9998	Gastrostomy/Jejunostomy tube, low-profile, any material, any type, each

Effective with date of service January 1, 2008, the following codes were added to the Home Health Fee Schedule and replace the codes listed above.

CODE	DESCRIPTION	UNIT	MAX ALLOWED RATE
B4087	Gastrostomy/Jejunostomy tube, standard, any material, any type, each	each	$17.81
B4088	Gastrostomy/Jejunostomy tube, low-profile, any material, any type, each	each	$137.02

EDS, 1-800-688-6696 or 919-851-8888

Attention: NCECS WebTool Users

Electronic Claim Submission

Electronic claims billed through the NCECS WebTool must be transmitted and completed by 5:00 p.m. on the checkwrite schedule cut-off date to be included in the next checkwrite. Any claims transmitted after 5:00 p.m. will be processed in the next scheduled checkwrite following the transmission date.

Please Note that NCECS WebTool users can submit claims **anytime before the transmitted date listed on the check write** schedule. All claims received daily are retained to ensure incorporation into the check write scheduled for that week.

Using the NCECS Webtool and submitting claims daily and prior to the scheduled checkwrite cut-off date will ensure claims are processed in the upcoming checkwrite, and eliminate any possible delays.

EDS, 1-800-688-6696 or 919-851-8888

Attention: Physician and Nurse Practitioners

Correction to "Drugs Added to the Physician's Drug Program - Billing Guidelines"

Nelarabine (Arranon)—HCPCS Procedure Code J9261

The correct ICD-9-CM diagnosis codes required for billing nelarabine are V58.11 (chemotherapy admission or encounter) **AND** 204.00 through 204.01 (lymphoblastic leukemia) **OR** 200.10 through 200.18, 200.20 through 200.28 or 202.80 through 202.88 (lymphoblastic lymphoma). One unit of coverage is 50 mg. Physicians and nurse practitioners may bill for this drug.

EDS, 1-800-688-6696 or 919-851-8888

Attention: Personal Care Services and Personal Care Services–Plus Personal Care Services Provider Training Sessions

The Carolinas Center for Medical Excellence (CCME; http://www2.thecarolinascenter.org/ccme/) announces continued provider training for Personal Care Services (PCS) as approved by the Division of Medical Assistance (DMA).

The 1st calendar quarter training sessions (PCS Provider Training Session VII) of 2008 will be conducted in March 2008. The training is recommended for registered nurses, agency administrators and agency owners who have a working knowledge of the PCS program and applicable DMA policies.

Dates and locations will be posted on CCME's Web site under "Upcoming Events." Pre-registration is required and space is limited to 150 participants at each session. Registration will be provided online or by fax. **To register online,** visit CCME's Web site and click on the appropriate link in Upcoming Events. When you have completed the online registration, you will receive a computer-generated number to confirm your registration. Bring the number with you to the session. **To register by fax,** complete the form following this announcement and fax it to the attention of Jennifer Manning or Alisha Brister at 919-380-9457. A member of the PCS team will contact you with a registration number, which you should bring with you to the session. If you need to **cancel** at any time, please contact Jennifer Manning (919-380-9860, x2018) or Alisha Brister (x2033) to allow others to register. Please e-mail Alisha Brister at CCME (abrister@thecarolinascenter.org) for further information on registering.

Sign-in will start at 8:00 a.m. at each location. The presentations will begin at 9:00 a.m. and run through 1:30 p.m., with one or two 15-minute breaks. Please plan ahead for the late lunch hour, as coffee, hot tea and water will be the only refreshments provided. This schedule allows us to offer 4.25 Continuing Nursing Education (CNE) contract hours to all nurses at no cost to the participants. **Considering the variability in meeting room temperature, please dress in layers to ensure your personal comfort.**

EDS, 1-800-688-6696 or 919-851-8888

The Carolinas Center *for* Medical Excellence

CCME PCS Provider Training Session 7
March, 2008
Registration form

Location requested: _____ Location Date: _____

First Name: _____

Last Name: _____

Credentials: _____

Position: _____

Organization: _____

Facility: _____

Address: _____

City: _____, NC Zip: _____

County: _____

UPIN/Provider #: _____

Phone #: _____ Ext: _____

Fax #: _____

Email: _____

Referred by/How did you hear about this event?

May we send you e-mail updates on new information, features, and tools on the CCME web site?
please check: ☐ Yes ☐ No

_____

_____

Please fax completed form to the attention of
Jennifer Manning at 919-380-9457

Attention: Outpatient Behavioral Health Service Providers, School Based Health Centers, Local Health Departments and Hospital Outpatient Departments

Reminders Regarding the Referral Process for Outpatient Behavioral Health Services

Prior to the initial outpatient behavioral health visit, recipients under the age of 21 require a referral by a Carolina Access (CA) Primary Care Provider (PCP), the LME or a Medicaid-enrolled psychiatrist. Practitioners who are employed and working for a CA Primary Care Physician or Medicaid-enrolled psychiatrist billing under the "incident to" guidelines will not need a referral. Services provided by a physician do not require a referral.

Referrals may be made by telephone, fax or in writing to the mental health provider. The referring provider will give the mental health provider a referral number that must be placed in block 17a of the CMS 1500 claim form in order for the claim to be paid. Failure to put the referral number on the claim when filing will result in denial of payment.

When obtaining referrals, providers are encouraged to include the referring NPI in block 17b; however, in some instances the referring LME will not have an assigned NPI. Due to the variance of services provided, not all LMEs are required to obtain an NPI.

Recipients age 21 and over do not require a referral.

Behavioral Health Services
DMA, 919-855-4290

Attention: All Pharmacists

Billing Outpatient Pharmacy Claims for Recipients with Retroactive Medicaid

In accordance with 10A NCAC 22J.0106(f), pharmacy providers may bill for outpatient pharmacy claims for recipients who are retroactively eligible for Medicaid. In that case, upon receipt of the Medicaid reimbursement, the provider is required to refund to the recipient all money paid by the recipient, with the exception of the co-payment amount, for the services covered by Medicaid. The provider is to base the refund on the actual amount paid by the recipient, not the amount reimbursed by Medicaid. There is no provision to allow the pharmacy provider to charge the recipient a processing or administrative fee. Failure to comply with federal or state regulations, N. C. Medicaid policy, or the N.C. Medicaid Provider Enrollment Agreement can result in sanctions including, but not limited to, termination from participation in the N.C. Medicaid program.

EDS, 1-800-688-6696 or 919-851-8888

Attention: Pharmacists and Prescribers

Requesting Changes to the Pharmacy Opt-In Provider

N.C. Medicaid recipients who receive more than 11 unduplicated prescriptions each month are required to opt in to a single pharmacy. The recipient's primary care physician and the current pharmacy provider are the only providers that may request changes to the pharmacy provider. Changes to a recipient's pharmacy provider may be requested by contacting EDS Provider Services at 919-851-8888 or 1-800-688-6696. EDS Provider Services staff is available Monday through Friday, between 8:30 a.m. and 4:30 p.m.

EDS, 1-800-688-6696 or 919-851-8888

Attention: UB/837I Billers

Medicaid Treatment of Private Insurance Plan Payments and Denials

Non-Compliance Denials

State and federal third-party liability (TPL) laws mandate that Medicaid not pay for services denied by private health plans due to noncompliance with the requirements of those plans. Common noncompliance denials include

- Non-participating provider
- Failure to obtain pre-approval
- Time filing deadline exceeded
- Service not provided in proper location
- Service not payable separately but is grouped for payment with other services, etc.

If the service would have been a covered service and payable by the private plan, but some requirement of the plan was not met, and the private plan denies payment, then Medicaid will not pay for this service.

The provider and the recipient both have responsibility for complying with private plan requirements. If the provider asked the recipient if there is coverage with a private plan, the recipient did not inform the provider of the existence of the recipient's private plan, and the plan's requirements were not met because the provider was unaware of them, then the provider may bill the recipient for those services if both the private plan and Medicaid deny payment due to noncompliance. Similarly, if a recipient fails to cooperate in any way in meeting any private plan requirement, the provider may bill the recipient for the service(s). Recipients are informed of their responsibility and that they may be billed for services that do not comply with their private plans. However, if the recipient presents the private payer information, and the provider is aware that the provider is not a participating provider in that plan or cannot meet any other private plan requirement, then before rendering any services the provider must inform the recipient that 1) the provider is a non participant in the plan or otherwise cannot meet one or more of its requirements and 2) the recipient will be responsible for payment.

When submitting paper claims to Medicaid with private insurance denials, the insurance company explanation of benefits (EOB) **must** be included with the claim, along with the explanation of any denial codes. If a claim is submitted with an insurance denial, and either the EOB or the denial code explanation is missing, the claim will be either returned to the provider as incomplete or denied for insufficient information.

Contracted Fee-For-Service Payments

The Medicaid program makes payment to providers on behalf of the recipients for medical services rendered, but is not an "insurer." As such, Medicaid is not responsible for any amount for

which the recipient is not responsible. If the recipient is not responsible for payment, then Medicaid is not responsible for payment.

Policy states that the TPL Amount Paid *plus* the Contractual Adjustment must be added together and deducted from the allowed amount. Medicaid will pay the difference, if there is one.

Example: If the TPL Paid Amount is $1,744.96 and the Contractual Adjustment is $233.95, the total TPL payment entered on the claim to Medicaid should be $1978.91. The fiscal agent will deduct $1978.91 from the Medicaid allowed amount.

TPL Overrides and EOB's Generally

With respect to paper claims, if the provider received a payment from a private plan, the provider may continue to indicate such payment on the claim and submit the claim without attaching the EOB. However, the provider must bill Medicaid only the amount for which the recipient is responsible, in accordance with the requirements outlined above. The contractual amount must be added to the third-party payment amount and submitted in the Prior Payments field (FL-54) on the UB. Additionally, pursuant to the Medicaid provider agreements and manuals, the provider must keep the EOB records on file for a period of three years. The Third Party Recovery (TPR) Section of DMA will conduct audits of provider records and billings, and providers will be required to provide copies of these EOB's. If no EOB is retained, Medicaid may recoup its payment made for the service(s). However, if the provider files a paper claim and receives a denial from a private plan, the EOB with the denial code explanation must be attached to the claim as stated above.

When submitting claims electronically, if the provider received a payment from a private plan, the provider may continue to indicate the payment amount as traditionally done; complying with the limitations set out above that Medicaid is responsible only for that which the recipient is responsible. The contractual amount must be added to the third-party payment amount and submitted in AMT Payer Prior Payment segment in Loop 2320 of the 837 for Institutional transaction. If the provider received a private plan denial, providers may use the following occurrence codes to override the TPL edits electronically: (1) code 24—Insurance Denied and Date and (2) code 25—Benefits Terminated and Date. Occurrence code 24, "Insurance Denied," is defined to mean **only** that the private plan denied payment because this service is not a covered service by this private plan. This means that the service never would have been covered under any circumstance. This does not mean that the plan denied payment for the service due to the provider's or recipient's noncompliance with that plan's requirements. As stated above with paper claims, the providers are required to retain the private plan EOB's for a period of three years, and the providers will be required to promptly submit copies of these EOB's upon request by DMA. As stated in the February 1994 Bulletin, if the provider does not provide the requested information within 30 days, the payment for that claim will be recouped without further contact with the provider.

All claims should be submitted to EDS for processing including the following:

Claims with a private plan denial for:

a) applied to the deductible
b) benefits exhausted

c) not a covered service, as defined above
d) pre-existing condition

Medicare eligible with no private insurance

Claims with a DMA-2057 form should be sent to TPR. The DMA-2057 form is to be used only for private health insurance, not Medicare update requests.

Claims for co-payments due from the recipients having capitated plans, as discussed in the May 1996 Bulletin article should be sent to EDS. Claims with a denial other than those listed above or attached to a DMA-2057, should be submitted directly to the TPR Section at 2508 Mail Service Center, Raleigh, NC 27699-2508.

EDS, 1-800-688-6696 or 919-688-6696

Attention: Residential Treatment Providers

Change to Cost Report Due Date for Calendar Year End Providers

The Division of Medical Assistance has extended the cost report due date to **May 31, 2008** for Mental Health Residential Treatment providers (Levels I through IV) with a fiscal year end of December 31, 2007. This extension is being allowed so that providers can submit the 2008 Residential Treatment Cost Report using their 2007 financial data.

For providers with a fiscal year end date prior to December 31, 2007, the cost report due date remains January 31, 2008.

The cost report and related training materials may be accessed through the DHHS website at http://www.ncdhhs.gov/dma/mentalhealth/mentalhealth.htm .

Rate Setting
DMA, 919-855-4200

Attention: All Institutional (UB04) Claim Filers

UB04 Changes to be Implemented April 25, 2008

The NUBC previously released the UB04 paper claim and manual for billing. DMA will be implementing claim processing modifications based on the UB04 manual on April 25, 2008. These changes apply to the UB04 paper claim form, 837I and NCECSWeb UB claim submission tool. Providers will receive a claim denial if they bill using any UB code which has been labeled by the NUBC in the UB04 manual as "Reserved for assignment by the NUBC". The impacted form locators and data elements are:

- FL 4 - Type of Bill (including the Type of Bill Frequency codes)
- FL 14 – Priority (Type) of Visit
- FL 15 – Source of Referral for Admission or Visit
- FL 17 – Patient Discharge Status
- FL 18-28 Condition Codes
- FL 31-34 Occurrence Codes and Dates
- FL 35-36 Occurrence Span Codes and Dates
- FL 39-41 Value Codes and Amounts
- FL 42 Revenue Code

Bill Type Changes

Due to a definition change in the UB04 Manual claims received on or after April 25, 2008 will be required to use the following Bill Types or the claim will deny:

- All hospitals should use Bill Type 11X for admits and discharges.
- Criterion #5 should use Bill Type 65X with Revenue Code 902. Previously Criterion #5 used Bill Type 14X.
- Residential Levels of Care I-IV should use Bill Type 86X. Previously Residential Levels of Care I-IV used Bill Type 84X.
- SNF Swing Beds and ICF Swing Beds should use Bill Type 18X. Previously SNF/ICF Swing Beds used Bill Type 15X, 16X, 18X, and 88X.
- Ventilator Nursing Facility bed services will continue to use Bill Type 28X.

Revenue Code Changes

Due to a definition change in the UB04 Manual claims received on or after April 25, 2008 for Adult Care Home services must use Revenue Code 679 in place of 599. Revenue Code 599 has been discontinued. Claims submitted with Revenue Code 599 will be denied.

Priority (Type) of Visit Changes
DMA will allow code 5 defined as Trauma in FL14 for claims received on or after April 25, 2008.

Patient Discharge Status Changes
DMA will allow code 70 defined as Discharged/transferred to another Type of Health Care Institution not Defined Elsewhere in this code list in FL 17 for claims received on or after April 25, 2008.

EDS, 1-800-688-6696 or 919-851-8888

Proposed Clinical Coverage Policies

In accordance with Session Law 2005-276, proposed new or amended Medicaid clinical coverage policies are available for review and comment on DMA's Web site at http://www.ncdhhs.gov/dma/prov.htm. To submit a comment related to a policy, refer to the instructions on the Web site. Providers without Internet access can submit written comments to the address listed below.

Loretta Bohn
Division of Medical Assistance
Clinical Policy Section
2501 Mail Service Center
Raleigh NC 27699-2501

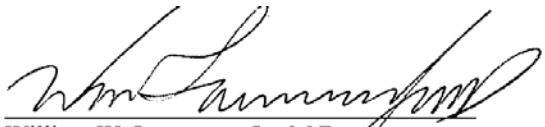
The initial comment period for each proposed policy is 45 days. An additional 15-day comment period will follow if a proposed policy is revised as a result of the initial comment period.

2008 Checkwrite Schedule

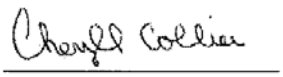
Month	Electronic Cut-Off Date	Checkwrite Date
February 2008	01/31/08	02/05/08
	02/07/08	02/12/08
	02/14/08	02/19/08
	02/21/08	02/28/08
March 2008	02/28/08	03/04/08
	03/06/08	03/11/08
	03/13/08	03/18/08
	03/20/08	03/27/08

Electronic claims must be transmitted and completed by 5:00 p.m. on the cut-off date to be included in the next checkwrite. Any claims transmitted after 5:00 p.m. will be processed on the second checkwrite following the transmission date.

EDS, 1-800-688-6696 or 919-851-8888



William W. Lawrence, Jr., M.D.
Acting Director
Division of Medical Assistance
Department of Health and Human Services



Cheryll Collier
Executive Director
EDS